

be performed. Finally, electroanatomical mapping system should be available for all procedures in patients with IART late after open-heart surgery, even when the ECG is consistent with counterclockwise IDAF.

Study limitations

No attempts were made to characterise potential low atrial circuits around the vena cava in association with IDAF. Pericaval circuit in association with IDAF is not clinically relevant since radiofrequency ablation of CTI interrupts both circuits.

During follow-up, there was no attempt to systematically document asymptomatic arrhythmias in the patients who initially presented with symptomatic IART, and asymptomatic IART, atrial fibrillation and other arrhythmia could have been missed. However, this is unlikely since arrhythmia drug treatment was discontinued in all patients with successful ablation.

CONCLUSIONS

In conclusion, dual-loop circuits should be systematically anticipated in patients with IART late after open-heart surgery and should be suspected in case of tachycardia change during radiofrequency ablation. Tachycardia transformation is strongly suggestive of dual-loop IART but hard to notice in some cases. Comparison of entrainment mapping data at critical sites before catheter ablation and after tachycardia change allows us to establish the diagnosis. The circuits delineated so far have a distinctive pattern including an isthmus dependant atrial flutter and a peritriotomy circuit. Electroanatomical mapping appears useful to delineate a tachycardia isthmus of peritriotomy circuits.

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